Philosophically-Informed Psychotherapy

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Abstract

Objective: To present an example of how a careful analysis of the philosophical presuppositions of certain psychiatric/psychological concepts and theories can ultimately benefit clinical practice in demonstrable ways.

Method: A method of systematically analyzing, explicating, and organizing the philosophical presuppositions of various psychological/psychotherapeutic theories has been developed. Using this “Hierarchy of Levels of Theoretical Inquiry” method the concept of “transference” is examined and the implicit philosophical paradigm on which its traditional definitions are based is elaborated. This set of philosophical assumptions is then contrasted with those of an alternative, phenomenologically-based model. The appropriateness of these two paradigms is then furthered reflected upon in terms of some clinical experiences with the phenomena in question.

Results: The two differing underlying philosophical paradigms discussed yielded quite different understandings of the nature of so-called “transference” phenomena. Conducting such a philosophical analysis in the manner described allowed this author to more clearly reflect upon the clinical phenomena in question in a way that helped enrich his understanding of them and benefited his clinical practice.

Conclusions: Direct practical consequences at an applied or clinical level can be shown to follow from theory-choices made on a philosophical-theoretical level. In the particular case of the concept of “transference” a more philosophically-informed approach to psychotherapeutic theory and practice may provide added depth to our understandings of the clinical phenomena in question.

Clinical Implications: A careful and systematic look at underlying philosophical presuppositions may yield clear benefits to clinical practice. An accessible and clinician-friendly method for doing so is available. A phenomenological model re-conceptualizes “transference” in a way that may deepen clinical understandings.

Limitations: Small sample size. This paper is essentially a “case demonstration” of how this approach has been helpful in one clinician’s practice. Larger sample studies with multiple clinicians, including ones with less extensive philosophy backgrounds, would be optimal and a desirable follow-up.

Key Words: philosophical presuppositions, “knowing thy philosophical self,” psychotherapy, transference, a phenomenological model.
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Background

In a day and age in which a generally pragmatic attitude dominates clinical practice the value and relevance of theoretical and philosophical work is often challenged in the contemporary psychiatric field. Such efforts are often met with much scepticism and theorists are readily confronted with the question: “Show me how it makes a clinical difference.” The practice of psychotherapy is certainly no exception in this regard.

Psychotherapy in its various forms is still one of the world’s most frequent treatment modalities in the mental health field. It might also be seen as the field’s most directly philosophical approach in that its basic subject-matter is to deal with the varying “world-views,” “belief systems,” and “experiential worlds” of its participants. Questions and assumptions about the nature or structure of human experience, and about the nature or structure of truth and reality permeate both our psychotherapeutic encounters and our conceptualizations of them (1,2,3,4,5). This is so even if these presuppositions lay largely hidden in the shadows (6,7,8,9,10,5,11).

Yet it often remains difficult to demonstrate at a pragmatic level how the differing theoretical and philosophical foundations of the various approaches to
psychotherapy affect both the ways they proceed and the degrees to which they are successful. To do this one would want some specific examples of situations where a particular theory or set of philosophical assumptions of “type A” can be shown to lead to a different understanding of clinical phenomena and a different clinical approach to be taken, as contrasted with what a theory/philosophy of “type B” would dictate. That form of argument would be a robust demonstration of the clinical relevance and importance of theory in general, and of these theory-choices in particular. Demonstrations of that type however can be hard to come by, but this paper attempts to provide one.

Some very central and valuable concepts in the psychotherapeutic literature have significant problems with them both clinically and philosophically. And despite numerous years of struggling with these on a clinical level the concepts still seem lacking in certain ways in terms of their really suiting the experiential and interactional phenomena in question. I will argue that in some instances this is because these concepts are grounded on a set of philosophical assumptions which ill-fit their subject-matter (i.e., that of human experience). To show this requires one to step back and cut lower into the philosophical-theoretical foundational levels of discussion in order to elucidate the problem from where it originates (9,5).

The concept of “transference” is one of these notions. It is a valuable and central concept which I believe, however, can be greatly strengthened in both appropriateness and utility if it is philosophically better understood and re-
conceptualized. Below I describe an instance in which some philosophical analyses and reflections on the concept of transference allowed me to revisit and better understand the clinical phenomena in question in a way that ultimately helped my work with patients. It also demonstrates the usefulness that a dialogical or “to and fro” relationship between theory and practice may have.

Method

We all know that there is presently a plethora of theories, schools, or approaches available to the modern psychotherapist. And one’s choice of theory is a very complex matter. But one of the important variables which doesn’t always get sufficient attention has to do with the philosophical foundations of the psychiatric/psychological theories which we practice. Different psychiatric theories and psychotherapeutic approaches are often founded upon differing sets of philosophical presuppositions, but (as I have argued extensively elsewhere) each of them may be seen to rely upon some set of epistemological and ontological assumptions (5, 9, 8).

The problem is that frequently in both the literature and practice of psychotherapy one’s philosophical presuppositions are left at only a vague, imprecise, and implicit level and occasionally they are outright disavowed. Yet these hidden assumptions continue to exert a highly significant influence upon the ways in which
the psychotherapist’s understandings of a particular case or issue will be framed, organized, or subtly structured. Given this situation it would be advantageous for us to be more explicitly aware of such pre-reflective philosophical biases. One might otherwise phrase this as stressing the value of “making our philosophical unconscious more conscious” (5, 9) and of trying to better “know thy philosophical self” (5, 9).

Part of the problem for many clinicians with this task has been methodological. Even as they become increasingly aware of the importance of philosophical issues they often lack the time or academic training to examine them in an accessible and practically useful way. For those reasons I have developed a methodology with which interested theorists and clinicians might more readily explore some of the important philosophical bases of our psychiatric/psychological theories in a systematic manner. The resultant heuristic device developed for this purpose is called the “hierarchy of levels of philosophical inquiry and their questions” (which has been published in journal form elsewhere (9) and is developed extensively in the book From Philosophy to Psychotherapy: A Phenomenological Model for Psychology, Psychiatry, and Psychoanalysis (5)).

This hierarchy addresses a series of philosophical questions arising on a variety of levels as may be seen on Chart #1 (adapted from 5, p 18):

[insert chart #1 about here]
Psychiatric or Psychological Level Theories are envisaged here as resting on a foundation of assumptions adopted at several lower, or more fundamental levels including those of the Ontological and Epistemological Levels of inquiry, as is illustrated by Figure #1: (from 5, p 19).

This method has since been used to develop what I’ve called “hierarchical sketches” (5, p 297; 9) of the philosophical assumptions underlying a number of psychotherapeutic approaches (5, p 297-340; 9). The development of a hierarchical sketch of a given psychological theory involves the investigation and characterization of its apparent assumptions or basic positions adopted with respect to the central questions posed at each of the levels of the hierarchy. This can then provide a useful overview or summary of the broad philosophical paradigm it embraces.

These sketches have been applied to such tasks as the explication of a particular psychological / psychotherapy theory, assessing its internal consistency, and in assessing the level of inquiry at which a given argument made within a theory may best apply. They can also be very useful in making philosophical comparisons among different psychological theories. I have also used this hierarchical approach to develop a theory of psychotherapy based on a phenomenological philosophical (largely Heideggerian) grounding (12,13,14,15,16,5) known as the “Beams-of-Light-Through-Time” model (5, 17). Overall this structured method might be seen as a
helpful tool with which to keep one’s clinical work more “philosophically-informed.”

The Concept of Transference and the Philosophical Assumptions Implied in Its Traditional Definition

The busy clinician’s question at this point always comes back to: “So what? Does it make any practical difference to you? Does it or can it make you a better psychotherapist? and How?” My experience is that it indeed does make a practical difference. I will use the example of how my own understanding and approach to the notion of “transference” has changed as a result of my philosophical reflections to help demonstrate their clinical relevance.

Any psychotherapist whose training included some psychoanalytic or psychoanalytically-derived teachings will be familiar with the term “transference.” This has been an absolutely central concept in psychoanalysis and much of psychotherapy since it was first introduced by Sigmund Freud a century ago (18,19,20). Indeed it is thought in some circles that “dealing with the transference” (and the “counter-transference”) is really the basic task or “the bread and butter” of the psychotherapist (or psychoanalyst) (21,22). Debates about the extent, significance, pathology, and the universality of “the transference” are plentiful, and often quite heated. But the ontological and epistemological underpinnings of this notion often go unchallenged. And the phenomenology of these experiences is not always closely examined (23). Yet these may be crucial.
When I deal with patients this phenomenon in which they appear to be experiencing me or responding to me as if I was someone else in their past occurs quite regularly. By training I learned to spot these readily and identify them as “transferences.” I was also taught to search for such similar oddities of my own feelings called “counter-transferences.” This supposedly “merely descriptive” terminology was somewhat taken for granted as accurately describing a process in which, as classical analyst Ralph Greenson put it: “A displacement has taken place; impulses, feelings and defences pertaining to a person in the past have been shifted onto a person in the present.” (21, p 152) Greenson further went on to refer to transference as a distortion (citing Fenichel in this regard) and stated that: “The two outstanding characteristics of a transference reaction are: [that] it is a repetition and it is inappropriate” (21, p 155).

These phrases from Greenson’s classic psychoanalytic textbook seem clear enough and at first glance seemed to fit with what happens in practice. But in my attempts to explicate the implied philosophical foundation for such a notion I came across some disturbing reflections. Greenson’s notions of “displacement,” distortion, and “repetition” were particularly problematic for me.

A hierarchical sketch of a philosophical paradigm which summarizes the classical psychoanalytic view on which Greenson’s conceptualization of transference appears to be based is illustrated on Chart #2 (adapted from 5, p 305): 

[insert Chart #2 about here]
Of particular interest to us here is that at Levels B, C, and D of the hierarchy this model entails the adoption of: 1) an Ontological (Cartesian) Dualism (24,25) in which a radical separation between the subject and the object and their relative independence of each other is assumed, 2) an Objectivistic General Epistemology (1,2,5,6) in which undistorted truths are seen to exist and to arise from the object side of the above-mentioned ontological split, and 3) a Correspondence theory of truth (1, p 143-5; 5, p 94-9; 2) in which the truth-value of various notions can be ascertained by assessing how well they match with some “objective reality”-based template to which they may be compared.

**Comparison With An Alternative, Phenomenological Philosophical Paradigm**

The problem for me in all of this was that in my own philosophical analyses of these same underlying questions (coming from a phenomenological philosophical tradition) I came up with a very different set of positions in marked disagreement with the stances delineated above. Chart #3 is a comparison chart sketching out differences between these two models: the first column showing the set of philosophical stances associated with the model favoured in the traditional view of transference (as noted above) contrasted with those of the phenomenological,
“Beams-of-Light-Through-Time” model (5, p 337-40) as shown in the second column.

[insert Chart #3 about here]

Extensive discussions of the details of this chart are available elsewhere (9, 5) but are by and large beyond the scope of this paper. Therefore without going into excessive detail for our present purposes we can still see that the two models differ significantly, and they do so as far down on the hierarchy as Levels B, C, and D.

Consequently, it would have been quite inconsistent for me to simply go about my psychotherapy business in the same old way while recognizing that some of the core concepts I was utilizing were in direct conflict with my philosophical reflections on the nature of human experience, knowledge, temporality, relatedness, Being-in-the-World, etc. As that would simply not do, I found that my more “philosophically-informed” state then required me to further reflect and perhaps re-evaluate or re-interpret the clinical phenomena which I was still calling “transference.”

Clinical Impact of these Philosophical Differences (and Discussion)

Returning with a renewed scepticism to the clinical phenomena at hand I found the descriptions of Greenson which once seemed so clear now appeared to be quite lacking in certain ways. The whole idea of thoughts, feelings, impulses,
emotions, or “transferences” existing as discreet, displaceable entities didn’t fit with the Heideggerian concept of Being-in-the World, but more importantly it didn’t quite fit with my clinical experiences of these phenomena either.

When a patient reacts and seems to experience me in similar fashion to, for example, how she felt towards her father it doesn’t feel like anything from the past is actually being “moved” or “transferred.” For one thing, if that was the case, in the presence of a father-transference in the therapy one should not feel it elsewhere anymore, including towards one’s father. We wouldn’t expect something which has been “transferred” to still be in its old location too. It shouldn’t be in two places at the same time. Yet frequently in clinical practice we see precisely that; that is, patients will have a very similar quality of relating to a number of different people in their lives, often simultaneously.

Of course the personal-historical origin of these patterns may be substantially linked to one’s past relationships with significant others. But on close examination of my own experiences of such moments in numerous psychotherapies these repetitive feelings seem only to be similar and familiar to those of the past, not exact replicas of them. They do not get re-enacted quite as if they were merely ‘pre-recorded’ tapes being played back again; and it appears that nothing is actually “transferred en masse” atomistically from the past into the present (1,5). Rather, each new instance seems to have its unique and present form to it too.

For example, the patient with a “father-transference” may make a dismissive
and sarcastic remark to the therapist and expect a harsh rebuke as was typically the case in her relationship with her father. But even so, the non-psychotic patient in the office generally does not expect the slap in the face or beating with which her abusive father would usually respond. She expects harsh treatment, but in the present context she expects that to be of a verbal not a physical nature. In that case the transference expectations can be seen to have been contextualized. It is not really a displaced repetition so much as a new variation on an old, albeit a repetitive, theme.

This continuance of old themes might alternatively be conceptualized in terms of a marked limitedness to this patient’s “imaginative horizons” such that her ways of relating to others become very few and are limited in this way (26). She may simply suffer from a diminished “repertoire” of imaginable relationship possibilities, patterns or expectations. And such an explanation would not require the complicated mechanics of the Cartesian-sounding “displacement of mental entities” at all (as suggested by the traditional model).

Another important point is that when such “transference” phenomena do occur in the psychotherapy context it always seems to me that these are indeed very interactional phenomena, (27, 5) that how I am with the patient at that moment is an integral part of exactly what and how the particular variants on these old themes will develop. In other words, I and my feelings are not merely incidental to the quality of some “pre-packaged” set of feelings which could come out anywhere just the same, with the name of “transference” attached to them. In practice it seems that what
actually goes on in the therapy room is a far more interactional, “co-constituted” (5, p 146), and “emergent” (5, p 339) set of phenomena that cannot be well accounted for by the discreet-entity language of even a “transference-countertransference intersection,” or by the objectivistic epistemology it seems to imply. New terminology, with terms like “the co-experience” (5, p 338) may ultimately prove to be more helpful in capturing the depth of inter-relatedness present in such phenomena as they occur in practice.

One more major point of contention comes up with respect to the view of the transference as a “distortion” or as an “inappropriate” (21) experience. There is much controversy in the literature already about this. American psychoanalysts Robert Stolorow and George Atwood with their Intersubjectivity Theory have argued that the whole concept of “distortion” is an invalid bit of hubris on the part of objectivistic theorists (27). They, and others (28), have argued that to make such judgments about which experiences are “distorted” and which are not presumes too much of a privileged-position for the therapist with respect to “the truth.” They seriously question the very possibility of such “objectivity” on the part of the therapist as being epistemologically naïve, and in denial of the interactional or intersubjective importance of the therapist/analyst in the very construction or constitution of what “truths” may exist in the psychoanalytic situation. And if truths are to be seen as co-constituted by the interaction of the two participants in their particular context together, then the idea of comparing them with a so-called “objective template” (as
suggested by the Correspondence Theory of Truth) seems quite far-fetched too. (5)

Once more I have found my own clinical work to be quite affected by these reflections on the question of distortion. In fact, it seems to me that all experience, including my own, is so heavily structured and biased by the “cares” (5), concerns, intentions, and projects which make up the perceiver’s perspective that one could more aptly say that all experience is “distorted,” rather than “this one is and that one isn’t.”

In practice, a more epistemologically humble clinical approach also seems to convey a less judgmental and less condescending tone to the therapy, to which patients most often respond very favourably. One can still look at the likely unpleasant consequences to seeing things a certain way or acting upon such beliefs without necessarily claiming that these are “untrue” or “distorted.” And one can also emphasize the clinical value of learning to “expand one’s repertoire” in helping patients to “widen their imaginative horizons” regarding the scope of possible relationship patterns available to them. This idea of “expanding” both imaginative and action horizons describes a more phenomenological conceptualization of some of the major goals of psychotherapy. (26, 5) It is quite a different approach than one of trying to substitute “undistorted” perceptions for “distorted” ones.

Conclusion
In conclusion I believe that attending to such philosophical matters as I have mentioned above can indeed be a feasible and worthwhile task for the practicing psychotherapist. My own reflections on these matters have indeed changed many of my ways of experiencing, understanding, and participating in the psychotherapeutic encounter, and in so doing they alter the encounter itself. A dialogical relationship between theory and practice in which they mutually influence each other (as described in this paper) can help create a more “philosophically-informed psychotherapy.” And, of course, most importantly this does seem to be helpful and enriching to the process, both by my own estimation and from the feedback I’ve received from patients.
References


